

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Somerset

6025

Village or City Crisfield

(No. 9 S. 4th

Registration Dist. No. 265

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mr. John Adams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH About 1859
(Month) (Day) (Year)

7 AGE About 86 yrs. mos. ds. OR min. ?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Common laborer (grocery)
(b) General nature of industry, business, or establishment in which employed (or employer) Hauling for store.

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Frank Adams

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maggie Adams

(Address) 9 S. 4th St. Crisfield

15 Filed June 15, 1914 J. E. Kollins

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 16, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1914, to June 16, 1914.

that I last saw him alive on June 10, 1914.

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy Nephritis

(Duration) 2 yrs. mos. ds.

Contributory Apoplexy
Secondary

(Duration) 14 yrs. mos. ds.

(Signed) W. J. Barkley, M. D.
June 11, 1914 (Address) 309 W. Md. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Lawsans DATE OF BURIAL June 13, 1914

20 UNDERTAKER B. J. Adams ADDRESS Crisfield

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

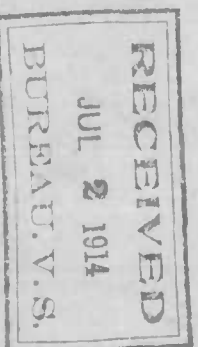
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The statement worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Garcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Somerset</u>		6026		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Crisfield</u> (No. _____)		Registration Dist. No. <u>265</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Aracula Bealsworth</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>			
6 DATE OF BIRTH <u>March 9th</u> , 18 <u>62</u> (Month) (Day) (Year)					
7 AGE <u>52</u> yrs. <u>3</u> mos. _____ ds. <u>OR</u> LESS than 1 day, _____ hrs. _____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Kingate Sterling</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Virginia Ford</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Virginia Sterling</u> (Address) <u>Crisfield, Md.</u>					
15 Filed <u>June 11</u> , 191 <u>4</u> <u>4</u> <u>E. E. Collier</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>June 9</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY that I attended deceased from <u>July 1</u> , 191 <u>4</u> to <u>June 9</u> , 191 <u>4</u> that I last saw him alive on <u>June 9</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>2 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Acute Myocarditis</u> (Duration) _____ yrs. _____ mos. <u>2</u> ds. Contributory <u>Chronic Diffuse</u> Secondary <u>Influenza</u> (Duration) _____ yrs. <u>12</u> mos. _____ ds. (Signed) <u>R. R. Thomas</u> , M. D. <u>June 9</u> , 191 <u>4</u> (Address) <u>Crisfield</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, It not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Bealsworths Cemetery</u> DATE OF BURIAL <u>June 10th</u> , 191 <u>4</u>					
20 UNDERTAKER <u>J. S. Lawson</u> ADDRESS <u>Crisfield</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

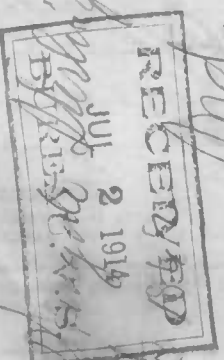
Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Somerset</u>		6027		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Morris</u> (No. _____) St.; _____ Ward _____		Registration Dist. No. <u>261</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Carrie Boyer</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Infant</u>			
6 DATE OF BIRTH <u>12-28-1912</u> (Month) (Day) (Year)					
7 AGE <u>1</u> yrs. <u>5</u> mos. _____ ds. _____		If LESS than 1 day, _____ hrs. _____ min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>"</u>					
9 BIRTHPLACE (State or country) <u> Md </u>					
PARENTS	10 NAME OF FATHER <u>Arthur Boyer</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u> Md </u>				
	12 MAIDEN NAME OF MOTHER <u>Carrie Gale</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u> Md </u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. E. Milburn</u> (Address) <u>Morris</u>					
15 <u>Filed</u> <u>6/26</u> , 191 <u>4</u> <u>J. J. Adams</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>6-28-1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Cholera - in infant</u> <u>No Dr. in attendance</u> <u>Dr. Colburn was called but found the child dead</u> Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>J. J. Adams</u> <u>MD</u> <u>6/26</u> , 191 <u>4</u> (Address) <u>Morris</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>St. Stephens</u>				DATE OF BURIAL <u>6/26</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Adrian</u>				ADDRESS <u>Morris</u>	

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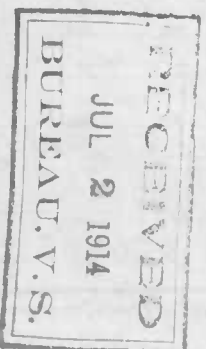
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1 PLACE OF DEATH County <u>Severna</u>		6028		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Wet Vernon</u>		(No. <u>69</u>)		Registered No. <u>263</u>	
2 FULL NAME <u>Willard Ready Currey</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>May 9, 1897</u> (Month) (Day) (Year)					
7 AGE <u>17</u> yrs. <u>1</u> mos. <u>0</u> ds. <u>0</u> hrs. <u>0</u> min. ? It LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Baltimore Md</u>					
PARENTS					
10 NAME OF FATHER <u>John S Currey</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Severna Co</u>					
12 MAIDEN NAME OF MOTHER <u>Virginia A. Hoffman</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Severna Co</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Willard Currey</u> (Address) <u>Severna Co Md</u>					
15 Filed <u>June 11, 1914</u> <u>W. M. Mark</u> <u>local</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>June 9, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>June 8, 1914</u> to <u>June 9, 1914</u> that I last saw him alive on <u>June 9, 1914</u> and that death occurred on the date stated above, at <u>11 A</u> m. The CAUSE OF DEATH* was as follows: <u>Apoplexy</u> (Duration) yrs. mos. ds. Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) <u>H. H. Barnes</u> , M. D. <u>June 11, 1914</u> (Address) <u>Severna Md</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, It not at place of death? Former or usual residence.....					
19 PLACE OF BURIAL OR REMOVAL <u>Wet Vernon Md</u>				DATE OF BURIAL <u>June 11, 1914</u>	
20 UNDERTAKER <u>E. C. Watson</u>				ADDRESS <u>Severna Md</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

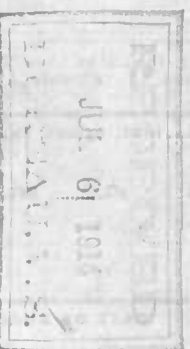
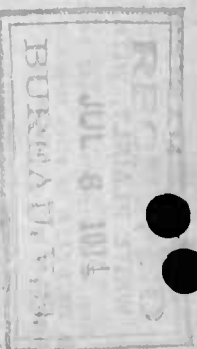
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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6029

County SomersetSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 260Village or City Bowie Anne (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant Clark

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

June 6th, 1914
(Month) (Day) (Year)

7 AGE

Seven months
yrs. mos. ds.If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Inf.

PARENTS

10 NAME OF FATHER

Joseph S. Clark11 BIRTHPLACE OF FATHER
(State or country)Kent Co. Inf.

12 MAIDEN NAME OF MOTHER

Eleanor W. Adams13 BIRTHPLACE OF MOTHER
(State or country)Somerset Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph S. Clark

(Address)

Bowie Anne Inf.

15

Filed

6/6, 1914
J. J. Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 6th, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

_____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas. W. Waring Jr., M. D.
6/6, 1914 (Address) Bowie Anne Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bowie Anne Inf.6/7, 1914

20 UNDERTAKER

ADDRESS

E. O. WatsonBowie Anne Inf.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

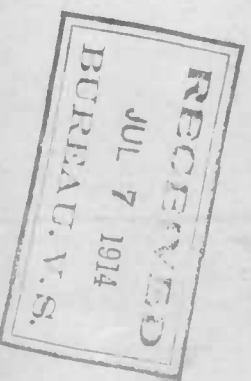
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tranition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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6030

184

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 260

[It death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

1 PLACE OF DEATH

County Dorchester Co.

Village or City Princess Anne (No. _____, St.; _____ Ward)

2 FULL NAME Wm. Collins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Apr. 9, 1914
(Month) (Day) (Year)

7 AGE 2 yrs. 10 mos. 18 ds. It LESS than
1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Dorchester Co.

10 NAME OF FATHER Wm. Collins

11 BIRTHPLACE OF FATHER (State or country) Dorchester Co.

12 MAIDEN NAME OF MOTHER Rose Doshier

13 BIRTHPLACE OF MOTHER (State or country) Dorchester Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. Collins

(Address) Princess Anne md

15 Filed 6/20, 1914 J. Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 19, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
W. D. 191, to _____, 191, that I last saw him alive on _____, 191

and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Probably "Bronchitis Pneumonia"

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. Smith, M. D.
6/20, 1914 (Address) Princess Anne

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Princess Anne DATE OF BURIAL 6/20, 1914

20 UNDERTAKER Wm. James ADDRESS Princess Anne md

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

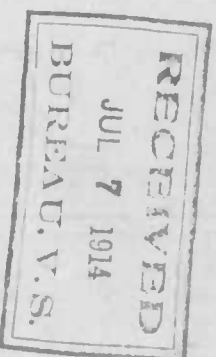
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, STOLIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			6031		151		STATE OF MARYLAND CERTIFICATE OF DEATH		265	
County <u>Somerset</u>			Village or City <u>Crisfield</u>		(No. _____)		St.; _____ Ward _____		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>no name</u>			Cullen							
PERSONAL AND STATISTICAL PARTICULARS										
3 SEX <u>M</u>		4 COLOR OR RACE <u>W.</u>		5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>						
6 DATE OF BIRTH <u>June 8</u> , 19 <u>14</u>		(Month) (Day) (Year)								
7 AGE _____ yrs. _____ mos. _____ ds.		If LESS than 1 day _____ hrs. _____ min. ?								
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u>		(b) General nature of industry, business, or establishment in which employed (or employer) <u>now</u>								
9 BIRTHPLACE (State or country) <u>Asbury District Md</u>										
PARENTS	10 NAME OF FATHER <u>George J. Cullen</u>									
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>									
	12 MAIDEN NAME OF MOTHER <u>Oliver C. Lora</u>									
13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>										
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE										
(Informant) <u>W. F. Keel</u>										
(Address) <u>Crisfield Md</u>										
15 Filed <u>June 9</u> , 19 <u>14</u>		4 <u>L. E. Collins</u>		REGISTRAR						
2 If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.										
MEDICAL CERTIFICATE OF DEATH										
16 DATE OF DEATH <u>June 7</u> , 19 <u>14</u>										
(Month) (Day) (Year)										
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,										
that I last saw him alive on <u>June 8</u> , 191 <u>4</u>										
and that death occurred on the date stated above, at <u>10:30</u> a.m.										
The CAUSE OF DEATH* was as follows: <u>Difficult birth</u> <u>Instrumental delivery</u>										
(Duration) _____ yrs. _____ mos. _____ ds.										
Contributory _____										
Secondary _____										
(Signed) <u>W. F. Keel</u> , M. D.										
June <u>7</u> , 191 <u>4</u> . (Address) <u>Crisfield</u>										
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.										
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)										
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.										
Where was disease contracted, If not at place of death? _____										
Former or usual residence _____										
19 PLACE OF BURIAL OR REMOVAL <u>Crisfield</u>										
DATE OF BURIAL <u>June 7</u> , 191 <u>4</u>										
20 UNDERTAKER <u>I. S. Lawson</u>										
ADDRESS <u>Crisfield</u>										

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

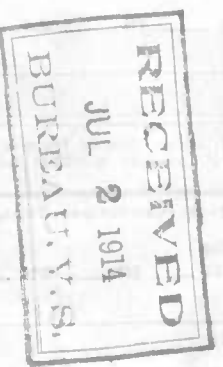
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6032
County Somerset

Village or City CHANCE MD (No. 150)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 268

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Elizabeth J. Dashiell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH Apr, 1930
(Month) (Day) (Year)

7 AGE 84 yrs. 2 mos. ds. OR 1 day, hrs. min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Noah Kelly

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Daniel

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob Tyler

(Address) CHANCE MD

15 Filed June 16, 1914 Geoff. Warner

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH JUN 14 1914, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from FEB 22 1914, 1914, to JUN 14 1914, 1914.

that I last saw her alive on JUN 14 1914, 1914.

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory Sensibility
Secondary

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) E. P. Simpson, M. D.
JUN 15 1914 (Address) CHANCE MD

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. Is the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL CHANCE MD DATE OF BURIAL JUN 16 1914

20 UNDERTAKER Leonard Webster ADDRESS Deals Island

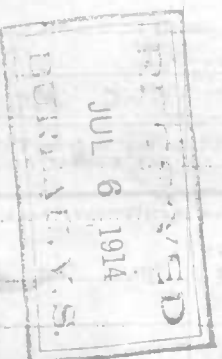
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coaling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

6033

(154)

1 PLACE OF DEATH
County Somerset

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 268

Village or City Deale's Island (No. 153) St. _____ Ward _____

2 FULL NAME Elizabeth C. Gibson

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Oct. 10, 1857
(Month) (Day) (Year)

7 AGE 76 yrs. 8 mos. 18 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE
(State or country) Morgantown, Somerset Co.

PARENTS

10 NAME OF FATHER John Wilson

11 BIRTHPLACE OF FATHER
(State or country) Morgantown

12 MAIDEN NAME OF MOTHER Elizabeth Wilson

13 BIRTHPLACE OF MOTHER
(State or country) Morgantown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George H. Gibson
(Address) Deale's Island Md

15
Filed _____, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 28th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1914 to June 20th, 1914, that I last saw him alive on June 1st (day), 1914 and that death occurred on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:
Death purely the result of Senile Decay

(Duration) 1 yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. B. Alderson, M. D.
June 30th, 1914 (Address) Deale Island

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL J. W. Henry **DATE OF BURIAL** July 1, 1914

20 UNDERTAKER Deale's Island **ADDRESS** Deale's Island

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

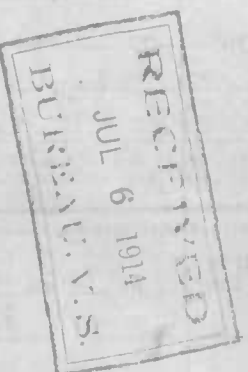
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Somerset Co

6034

(120)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 261

Village or City

Marion

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Jane Holden

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Col

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

not born

(Month)

(Day)

1899 (Year)

7 AGE

55

yrs.

mos.

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Virginia

PARENTS

10 NAME OF FATHER

Mathias

11 BIRTHPLACE OF FATHER (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Dora Hunt

13 BIRTHPLACE OF MOTHER (State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jane Holden

(Address)

Marion

15

Filed

4/11-1914

F. J. Adams

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June

11

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1914

to June 11, 1914

that I last saw him alive on June 10, 1914

and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Chronic mitral regurgitation
Cardiac infarction
Hypertensive pneumonia

(Duration) yrs. mos. ds.

Contributory Secondary

Myocarditis (Duration) 1 yrs. mos. ds.

(Signed) George C. Coulbourne, M. D.

June 11, 1914 (Address) Marion Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place

of death yrs. mos. ds.

In the

State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

St. Stephen

DATE OF BURIAL

4/12, 1914

20 UNDERTAKER

A. W. Dittus

ADDRESS

Marion

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

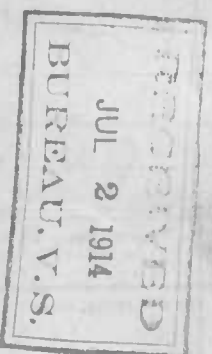
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

6035

County

Somerset

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

460

Village or City

Bowie

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Joe Jones (James)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Brown

5 SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Jan 28, 1842
(Month) (Day) (Year)

7 AGE

72 yrs. 5 mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer)

Alms house

9 BIRTHPLACE

(State or country)

Md.

PARENTS

10 NAME OF FATHER

Joseph James

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary Jones

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elin Jones

(Address)

B. Ave. Md.

15

Filed

6/21, 1914 J. J. Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 21, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

1914 to 1914

that I last saw him alive on 1914

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bright's disease

(Duration) yrs. mos. ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

J. J. Smith

M. D.

6/21, 1914 (Address) Bowie, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bowie, Md.

6/22, 1914

20 UNDERTAKER

ADDRESS

Wm. Jones

B. Ave. Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

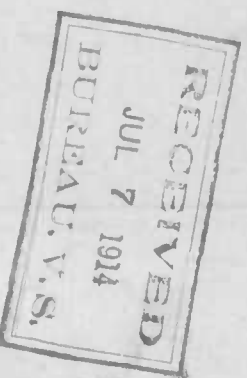
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1 PLACE OF DEATH 6036
County Somerset

Village or City Princes Anne (No. 119) St.; Ward

Registration Dist. No. 760

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Laura A James

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE African 5 SINGLE, Infant
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH April 13, 1914
(Month) (Day) (Year)

7 AGE 6 If LESS than
1 day, hrs.
yrs. mos. ds. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (State or country) Somerset Co.

10 NAME OF FATHER Levadaud James

11 BIRTHPLACE OF FATHER (State or country) Somerset Co.

12 MAIDEN NAME OF MOTHER Julia Logg

13 BIRTHPLACE OF MOTHER (State or country) Somerset Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. W. Waccorrell

(Address) Princes Anne Md

15 Filed 6/18, 1914 G. Smith

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6 16, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 6-14, 1914, to 6-16, 1914,

that I last saw h. SA alive on June 14, 1914.

and that death occurred on the date stated above, at 4 PM m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
The (Physician) Informant in this case
knows practically nothing, except
as above (Duration) yrs. mos. ds.

Contributory Unknown
Secondary

(Duration) yrs. mos. ds.
(Signed) Chas. W. Waccorrell, M. D.
6-16, 1914. (Address) Princes Anne Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Somerset Anne DATE OF BURIAL June 18, 1914

20 UNDERTAKER W. James ADDRESS Princes Anne

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

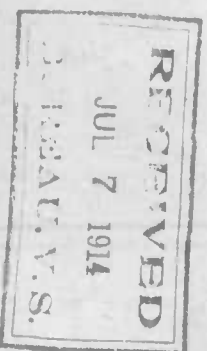
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Maunager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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¹ PLACE OF DEATH 6037
County Somerset

Village or City Upper Fairmount

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 264

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME

Samuel Johnson

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Male ⁴ COLOR OR RACE Colored ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

⁶ DATE OF BIRTH

unknown, 1
(Month) (Day) (Year)

⁷ AGE

about 74 yrs. — mos. — ds. OR 1 day, — hrs. OR ? min. ?

⁸ OCCUPATION

(a) Trade, profession, or particular kind of work farm laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE

(State or country) Somerset Co. Md

PARENTS

¹⁰ NAME OF FATHER

David Johnson

¹¹ BIRTHPLACE OF FATHER
(State or country)

Somerset Co.

¹² MAIDEN NAME OF MOTHER

Dora Johnson

¹³ BIRTHPLACE OF MOTHER
(State or country)

Somerset Co.

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laura Maddox

(Address)

Upper Fairmount

¹⁵

Filed June 26, 1914 G. E. Dickinson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH

June 25, 1914
(Month) (Day) (Year)

¹⁷

I HEREBY CERTIFY, That I attended deceased from

Sept 8, 1913 to June 24, 1914

that I last saw him alive on June 24, 1914

and that death occurred on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(Duration) 9 yrs. — mos. — ds.

Contributory
Secondary

(Duration) 9 yrs. — mos. — ds.

(Signed)

G. W. Gell

M. D.

June 26, 1914 (Address) Marshall Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

¹⁹ PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marshall Rd

June 26, 1914

²⁰ UNDERTAKER

ADDRESS

Herbert Wilson Upper Fairmount

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not faithfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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RECEIVED

JUL 8 1914

BUREAU U. S. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

6038

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty SomersetRegistration Dist. No. 265Village or City Beesfield (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Edmund Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE B5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH _____

(Month) (Day) (Year) 1871

7 AGE

39 yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Waterman

9 BIRTHPLACE (State or country)

Somerset Co. Md

PARENTS

10 NAME OF FATHER

John W Jones

11 BIRTHPLACE OF FATHER (State or country)

Somerset Co

12 MAIDEN NAME OF MOTHER

Jane Hughes

13 BIRTHPLACE OF MOTHER (State or country)

Somerset Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Francis Parker

(Address)

Beals Island

15

Filed _____, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 13, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1914, to June 13, 1914.that I last saw him alive on June 13, 1914.and that death occurred on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Acute Phthisis(Duration) about 1 year yrs. _____ mos. _____ ds.

Contributory Secondary

Bronchitis
(Duration) about 1 year yrs. _____ mos. _____ ds.(Signed) C. E. Coaling, M. D.June 17, 1914 (Address) Beesfield

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. 13 ds. In the State 39 yrs. _____ mos. _____ ds.Where was disease contracted, If not at place of death? about 1 yearFormer or usual residence Beals Island

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Beals Island Md June 14, 1914

20 UNDERTAKER

ADDRESS

L. E. White Beals Island

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

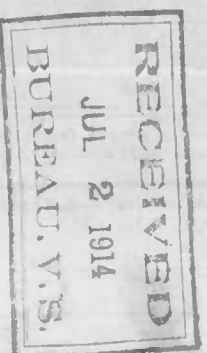
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH 6039
County Somerset

Village or City Chauce (No. 154)

2 FULL NAME Elizabeth J. Jones

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 26 P

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Nov 9, 1899
(Month) (Day) (Year)

7 AGE 74 yrs. 5 mos. — ds. If LESS than 1 day, hrs. OR mo. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Somerset Co

10 NAME OF FATHER John H. Jones

11 BIRTHPLACE OF FATHER (State or country) Somerset Co

12 MAIDEN NAME OF MOTHER Milly A. Rowe

13 BIRTHPLACE OF MOTHER (State or country) Somerset Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant John Jones

(Address) Chauce

15 Filed June 24, 1914 Geo B. Horner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 23, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1914, to June 23, 1914, that I last saw her alive on June 4, 1914

and that death occurred on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Chronic Stomachis and Intestinal Indigestion

(Duration) 30 yrs. — mos. — ds.

Contributory (Secondary) Emaciation and exhaustion (Duration) — yrs. — mos. — ds.

(Signed) E. P. Simpson, M. D.
June 24, 1914 (Address) Chauce Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Chauce

DATE OF BURIAL June 24, 1914

20 UNDERTAKER L. G. Webster

ADDRESS Deer Island

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

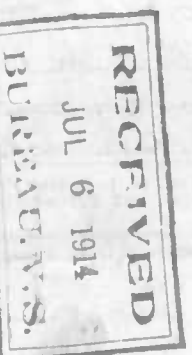
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH **6040**
 County **Somerset**
 Village or City **Landonville** (No. **S.**, St.; **Jones** Ward)
 2 FULL NAME **None** Registration Dist. No. **2644**

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX Male	4 COLOR OR RACE Black	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)
6 DATE OF BIRTH June 20, 1914 (Month) (Day) (Year)		
7 AGE Dead Born yrs. — mos. — ds.		If LESS than 1 day, — hrs. OR — min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) Maryland		
PARENTS	10 NAME OF FATHER William Jones	
	11 BIRTHPLACE OF FATHER (State or country) Virginia	
	12 MAIDEN NAME OF MOTHER Viola Johnson	
	13 BIRTHPLACE OF MOTHER (State or country) Maryland	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) William K. Johnson (Address) Landonville		
15 Filled June 21, 1914 H. E. Dickinson REGISTRAR		

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH June 20, 1914 (Month) (Day) (Year)	
17 I HEREBY CERTIFY, That I attended deceased from, 191..... to , 191..... that I last saw h..... alive on , 191..... and that death occurred on the date stated above, at m. The CAUSE OF DEATH* was as follows: Premature Birth (Duration) yrs. mos. ds. Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) H. E. Dickinson , M. D. June 21, 1914 (Address) Upper Fairmount	
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence	
19 PLACE OF BURIAL OR REMOVAL Centennial Church Yd	DATE OF BURIAL June 21st, 1914
20 UNDERTAKER W. K. Johnson	ADDRESS Landonville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

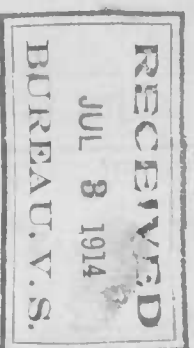
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word, or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—(on mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tantion," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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PLACE OF DEATH

6041

County

Somerset

Village or City

Crisfield

(No.

Registration Dist. No.

265

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Nash H. Laird

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE,
MARRIED,
WIDDED,
OR DIVORCED
(Write the word)

Married

DATE OF BIRTH

Oct 31st, 1849

AGE

64 yrs. 7 mos. 2 ds.

If LESS than
1 day.....hrs.
OR.....min.?

OCCUPATION

(a) Trade, profession, or
particular kind of work.

Mariner

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Washington on B.C. & A.
line steamboats in
winter
Crabber in summer

BIRTHPLACE
(State or country)

Crabber in summer
Maryland

NAME OF FATHER

John Laird

BIRTHPLACE
OF FATHER
(State or country)

Maryland.

MAIDEN NAME
OF MOTHER

Heziah Riggins

BIRTHPLACE
OF MOTHER
(State or country)

Maryland.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Julia Daugherty

(Address)

Washington, D.C.

15

Filed

Jun. 4, 1914

C. E. Collins

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

June 2, 1914

I HEREBY CERTIFY, That I attended deceased from

, 191, to , 191,

that I last saw him alive on , 191,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bright's Disease, found
dead in his boat

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. T. Simpson, M. D.

June 2, 1914 (Address) Crisfield Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDEN-
TAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Crisfield Cemetery June 4th, 1914

20 UNDERTAKER

ADDRESS

J. S. Dawson Crisfield

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

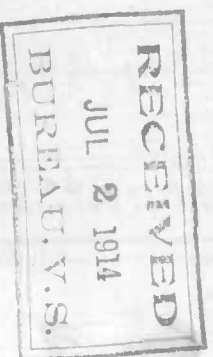
Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name or sign: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Somerset

Village or City Asbury District (No. 6042)

2 FULL NAME Caroline Lawson

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 265

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ♀ 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow
(Write the word)

6 DATE OF BIRTH March 1, 1830
(Month) (Day) (Year)

7 AGE 84 yrs 3 mos 21 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work housework
(b) General nature of industry, business, or establishment in which employed (or employer) at

9 BIRTHPLACE (State or country) Somerset Md

10 NAME OF FATHER Isaac Lawson

11 BIRTHPLACE OF FATHER (State or country) Asbury Md

12 MAIDEN NAME OF MOTHER Nancy Sterling

13 BIRTHPLACE OF MOTHER (State or country) Asbury Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. F. Howell

(Address) Crisfield Md

15 Filed June 27, 1914 E. E. Collins

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 24, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1914, to June 24, 1914
that I last saw her alive on June 24, 1914

and that death occurred on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Paralysis of muscles of deglutition

(Duration) ____ yrs. ____ mos. 17 ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. F. Howell, M. D.

June 24, 1914, (Address) Crisfield Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asbury Cemetery

June 26, 1914

20 UNDERTAKER

ADDRESS

I. S. Lawson

Crisfield

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

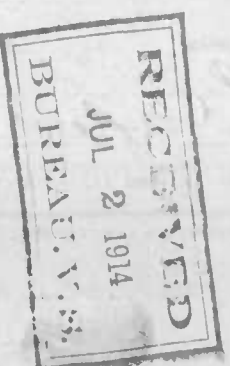
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6043

County HowardVillage or City Wettersville (No. 1)2 FULL NAME Isaac Foreyna LindseySTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 263

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single6 DATE OF BIRTH Aug 15, 1911
(Month) (Day) (Year)7 AGE 2 yrs. 9 mos. ds. If LESS than 1 day, hrs. OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Virginia10 NAME OF FATHER Charles Lindsey11 BIRTHPLACE OF FATHER (State or country) Virginia12 MAIDEN NAME OF MOTHER Francis Hall13 BIRTHPLACE OF MOTHER (State or country) Wettersville

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Francis Hall(Address) Francis Hall15 Filed June 3, 1914 J. H. Martin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 2, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 15, 1914 to June 2, 1914.that I last saw him alive on June 1, 1914and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis fever

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

Signed J. H. Martin, M. D.June 3, 1914 (Address) Wettersville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Wettersville DATE OF BURIAL June 3, 191420 UNDERTAKER Dechler Bros ADDRESS Wettersville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.¹

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.. *Carcin-*

oma, Sarcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUL 6 1914

BUREAU OF VITALS
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

RECEIVED
JUL 8 1914
BUREAU OF VITALS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Somerset

6044

(151)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 261Village or City Marion (No. _____) St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mossy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 30, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. 6 ds. OR LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Somerset Co

PARENTS
10 NAME OF FATHER S. Gordon Mossy
11 BIRTHPLACE OF FATHER (State or country) Somerset Co
12 MAIDEN NAME OF MOTHER Sarah Matthews
13 BIRTHPLACE OF MOTHER (State or country) Somerset Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. Gordon Mossy
(Address) Marion Md

16 Filed 6/6, 1914 J. J. Adams
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 5, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1914 to June 5, 1914

that I last saw her alive on June 5, 1914

and that death occurred on the date stated above, at 11-45 P. M.

The CAUSE OF DEATH* was as follows:

Detention & Exhaustion

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Detention
Secondary _____

(Signed) J. A. B. Allen M. D.
June 6, 1914 (Address) Marion Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, if not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St Pauls Church DATE OF BURIAL 6/7, 1914
20 UNDERTAKER Stuarts Bros ADDRESS Coronado

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUL 2 1914

BUREAU U. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

6045

1 PLACE OF DEATH

County SomersetVillage or City Yur Westover

(No.)

Registration Dist. No. 119

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant- Price

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant
(Write the word)

6 DATE OF BIRTH

May, 1914
(Month) (Day) (Year)

7 AGE

..... yrs. 1 mos. ds. If LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9 BIRTHPLACE (State or country)

Ind.

PARENTS

10 NAME OF FATHER

Richard Price

11 BIRTHPLACE OF FATHER (State or country)

Ind.

12 MAIDEN NAME OF MOTHER

Heronetta Wilson

13 BIRTHPLACE OF MOTHER (State or country)

Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oliver G. Gresham(Address) Westover

15

Filed 6/6, 1914 agb

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 6, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 4, 1914, to June 6, 1914.

that I last saw him alive on June 4, 1914.

and that death occurred on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) yrs. mos. 7 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Oliver G. Gresham, M. D.

6/6, 1914. (Address) Price's Avenue

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Price's Avenue June 6, 1914

20 UNDERTAKER

ADDRESS

Richard Price Westover

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

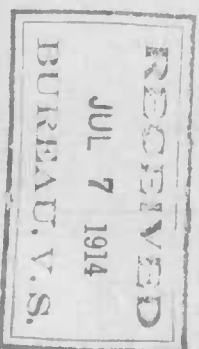
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 6046
 County Somerset
 Village or City Marion (No. 31) St. _____ Ward _____
 2 FULL NAME Henrietta Scott
 STATE OF MARYLAND
 CERTIFICATE OF DEATH
 Registration Dist. No. 2645
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married
 6 DATE OF BIRTH Dec 5, 1888
 (Month) (Day) (Year)
 7 AGE 25-7-0 If LESS than 1 day,hrs. ORmin. ?
 yrs. mos. ds.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housekeeper

9 BIRTHPLACE (State or country)

Marion Station

PARENTS

10 NAME OF FATHER

David P. Ward

11 BIRTHPLACE OF FATHER (State or country)

Marion Station

12 MAIDEN NAME OF MOTHER

Henrietta Johnson

13 BIRTHPLACE OF MOTHER (State or country)

Marion Station

I, THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David Johnson

(Address)

Onfield

16

Filed 6/5-1914 F. J. Adams
 REGISTRARSTATE OF MARYLAND
 CERTIFICATE OF DEATHRegistration Dist. No. 2645

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 5, 1914
 (Month) (Day) (Year)17 I HEREBY CERTIFY That I attended deceased from May 1, 1914 to May 28, 1914
 that I last saw her alive on May 28, 1914and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of mesenteric glands
 (Duration) 3 yrs. — mos. — ds.Contributory
 Secondary(Duration) 3 yrs. — mos. — ds.(Signed) C. C. Ward M. D.
6/6, 1914 (Address) Onfield

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Near Marion

DATE OF BURIAL

6/7-1914

20 UNDERTAKER

Adams

ADDRESS

Marion

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

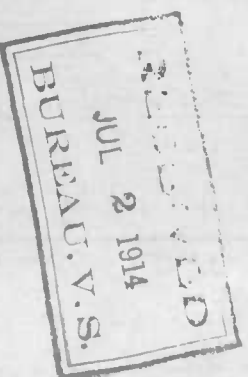
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by runaway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **6047**
 County Somerset **(154)**
 Village or City Princeton Avenue (No. _____) St. _____ Ward _____
 2 FULL NAME Louis Seguen
 Registration Dist. No. 260

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married
 (Write the word)
 6 DATE OF BIRTH 837
 (Month) (Day) (Year)
 7 AGE 87 yrs. 1 mos. 1 ds. OR LESS than 1 day, _____ hrs. _____ min. ?
 8 OCCUPATION (a) Trade, profession, or particular kind of work Retired Lake Captain
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 9 BIRTHPLACE (State or country) Detroit Mich

PARENTS

10 NAME OF FATHER John Seguen
 11 BIRTHPLACE OF FATHER (State or country) Not known
 12 MAIDEN NAME OF MOTHER Marguerite Debe
 13 BIRTHPLACE OF MOTHER (State or country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. John Robins

(Address)

Princeton Ave

15

Filed 4/151914J. G. Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH June 18, 1914
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from May 23, 1914, to June 18, 1914.

that I last saw him alive on June 14, 1914.

and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 1 yrs. 1 mos. 1 ds.

Contributory
 Secondary

(Duration) 1 yrs. 1 mos. 1 ds.

(Signed) Henry M. Lambford, M. D.
June 15, 1914 (Address) Princeton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
 if not at place of death?

Former or
 usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leedsbury Md.6/16, 1914

20 UNDERTAKER

ADDRESS

E. O. WalsonPrinceton Ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH **6048**
County Somerset

Village or City Crisfield District (No. 151)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 3

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME unnamed Somers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH June 28, 1911
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. OR _____ min. ?
It LESS than 1 day 72 hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Somerset

10 NAME OF FATHER Henry C. Somers

11 BIRTHPLACE OF FATHER (State or country) Somerset Co

12 MAIDEN NAME OF MOTHER Andrick B. Sterling

13 BIRTHPLACE OF MOTHER (State or country) Somerset Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Heale

(Address) Crisfield

15 Filed June 30, 1911 H. E. Collins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 30, 1911
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 1911, to _____, 1911,

that I last saw her alive on June 30, 1911

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Prognation birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. F. Heale, M. D.

July 1, 1911 (Address) Crisfield Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Crisfield

20 UNDERTAKER

I. S. Lawson

DATE OF BURIAL

June 30, 1911

ADDRESS

Crisfield

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

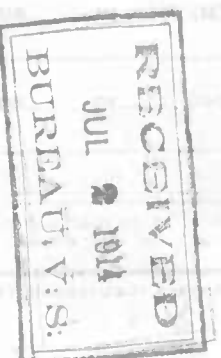
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 6049

County SomersetVillage or City Habnab (No., St. Ward)2 FULL NAME Mary W. SpenceSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 260

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH 1
(Month) (Day) (Year)

7 AGE yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Habnab Md

PARENTS
10 NAME OF FATHER James White
11 BIRTHPLACE OF FATHER (State or country) Habnab Md
12 MAIDEN NAME OF MOTHER Petsy E Smith
13 BIRTHPLACE OF MOTHER (State or country) Princes Anne Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe Spence
(Address) Grice Md.

15 Filed 6/30, 1914 J. Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 29, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1914, to June 29, 1914,
that I last saw him alive on June 29, 1914.

and that death occurred on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:

Tuberculosis
(Duration) 1 yrs. mos. ds.

Contributory Syncope
Secondary (Duration) yrs. mos. ds.

(Signed) James T. Reedy, M. D.
June 29, 1914 (Address) Grice Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Habnab DATE OF BURIAL 6/30, 1914
20 UNDERTAKER James T. Reedy ADDRESS Grice Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracilia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUL 7 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		6050		STATE OF MARYLAND		CERTIFICATE OF DEATH	
County		Somerset		Registration Dist. No.		[It death occurred in a hospital or institution, give its NAME instead of street and number.]	
Village or City		Onsfield (No.)		St.;		Ward)	
2 FULL NAME		no name		Sterling			
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX	F.	4 COLOR OR RACE	W.	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	single	16 DATE OF DEATH	June 7, 1914 (Month) (Day) (Year)
6 DATE OF BIRTH	June 7, 1914 (Month) (Day) (Year)			7 AGE	1 LESS than 1 day, hrs. yrs. mos. ds. OR min. ?	17 I HEREBY CERTIFY, That I attended deceased from	1914 to 1914
8 OCCUPATION	(a) Trade, profession, or particular kind of work			none	(b) General nature of industry, business, or establishment in which employed (or employer)	none	
9 BIRTHPLACE (State or country)	Onsfield Md			10 NAME OF FATHER	Howard L. Sterling	11 BIRTHPLACE OF FATHER (State or country)	Md
12 MAIDEN NAME OF MOTHER	Gineva Gibson			13 BIRTHPLACE OF MOTHER (State or country)	Md	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				19 PLACE OF BURIAL OR REMOVAL			
(Informant) W. F. Hall				DATE OF BURIAL			
(Address) Onsfield Md				June 7, 1914			
15 Filed June 7, 1914				20 UNDERTAKER			
B. E. Hollins				J. S. Sawson			
REGISTRAR				ADDRESS			
				Onsfield			

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) W. F. Hall, M. D.

June 7, 1914 (Address) Onsfield

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Former or usual residence.

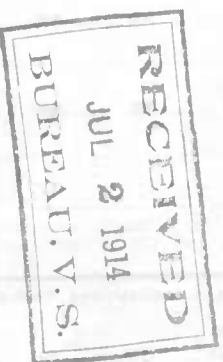
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fidential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6051

County

Somerset

Village or City

Morion

(No.

St.;

Ward)

2 FULL NAME

Mary E. Townsend

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 261

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

widowed

6 DATE OF BIRTH

June 24, 1845

(Month) (Day) (Year)

7 AGE

69

yrs. mos. ds.

35

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Somerset Co

PARENTS

10 NAME OF FATHER

Dont know

11 BIRTHPLACE OF FATHER

(State or country)

Somerset Co

12 MAIDEN NAME OF MOTHER

Dont know

13 BIRTHPLACE OF MOTHER

(State or country)

Somerset Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. O. Townsend

(Address)

Morion

15

Filed

6/30, 1914 F. J. Adams

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 29, 1914

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 27, 1914, to June 29, 1914

that I last saw her alive on June 27, 1914

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

24 hours +
Heart Failure

(Duration) yrs. mos. ds.

Contributory
Secondary

Semility

(Duration) yrs. mos. ds.

(Signed)

J. A. B. Allen, M. D.

6/30, 1914 (Address) Morion, Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

St Pauls

DATE OF BURIAL

6/30, 1914

20 UNDERTAKER

R. J. Adams

ADDRESS

Confield

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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RECEIVED
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BUREAU U. S. S.

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1 PLACE OF DEATH

6052

(40)

County

Somerset

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

261

Village or City

Marion Md

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mrs Mary Joseph Full

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

married

6 DATE OF BIRTH

Jan 28, 1952
(Month) (Day) (Year)

7 AGE

62 yrs. 4 mos. 12 ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

housework

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Somerset Md

PARENTS

10 NAME OF
FATHER

John B Bell

11 BIRTHPLACE
OF FATHER
(State or country)

Somerset Md

12 MAIDEN NAME
OF MOTHER

Elizabeth Horsey

13 BIRTHPLACE
OF MOTHER
(State or country)

Somerset Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Full

(Address)

Marion

15

Filed

6/11 1914 J J Madam

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 10, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Marion, 1914, to June 10, 1914,

that I last saw her alive on June 9, 1914,

and that death occurred on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac
Distraction

(Duration) yrs. mos. ds.

Contributory
Secondary

Coronary & Stomach

(Duration) yrs. mos. ds.

(Signed)

George C. Coulbourn, M. D.

June 10, 1914 (Address) Marion Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Pauls

6/11, 1914

20 UNDERTAKER

ADDRESS

A. W. D. W. W.

Marion

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

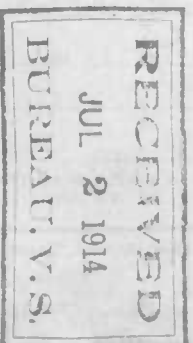
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Maunger," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 6053
County Somerset

Village or City New Weston (No. _____, St.; _____ Ward)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 260

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Levinia C. Waters

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Dec 22, 1849
(Month) (Day) (Year)

7 AGE 64 yrs. 5 mos. 22 ds. OR LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind.

PARENTS
10 NAME OF FATHER Wm Couper
11 BIRTHPLACE OF FATHER (State or country) Ind.
12 MAIDEN NAME OF MOTHER Hannah Couper
13 BIRTHPLACE OF MOTHER (State or country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Levinia C. Waters

(Address) New Weston

15 Filed 4/13, 1914 J. J. Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 13, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1914, to June 13, 1914, that I last saw him alive on June 11, 1914

and that death occurred on the date stated above, at 5:00 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 2 yrs. _____ mos. _____ ds.
Contributory Chronic nephritis
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Chas. F. Franklin, M. D.
6/13, 1914 (Address) Prison Avenue, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL New Preston City DATE OF BURIAL 6/15, 1914

20 UNDERTAKER Stinson Bros ADDRESS Preston City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

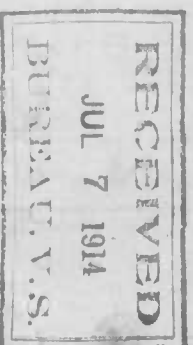
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Somerset

Village or City

Deals Island

(No.)

151

St.;

Ward)

2 FULL NAME

Nameless Infant Webster

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

268

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

—

6 DATE OF BIRTH

June 16, 1914
(Month) (Day) (Year)

7 AGE

yrs. mos. ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)

Md.

PARENTS

10 NAME OF
FATHER

George O. Weber

11 BIRTHPLACE
OF FATHER
(State or country)

Md.

12 MAIDEN NAME
OF MOTHER

Rosa Homer

13 BIRTHPLACE
OF MOTHER
(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leonard Boorman

(Address)

Deals Island

15

Filed

June 19, 1914 Geo. B. Barker

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 18, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 16, 1914, to June 18, 1914.

that I last saw her alive on June 18, 1914.

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

E. O. S. [Signature], M. D.
June 18, 1914 (Address) Deals Island*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Deals Island June 19, 1914

20 UNDERTAKER

ADDRESS

Dr. J. H. Hendry Deals Island

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting N. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

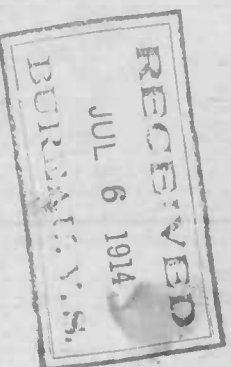
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1 PLACE OF DEATH

County

Somerset

Village or City

Champer

(No.

St.

Ward)

2 FULL NAME

*Katie White*STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

260

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*Colored*5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)*Married*

6 DATE OF BIRTH

April 9

(Month)

(Day)

1890
(Year)

7 AGE

24

yrs.

2

mos.

11

ds.

or LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Orisale Md

PARENTS

10 NAME OF FATHER

Edward Maddox

11 BIRTHPLACE OF FATHER

(State or country)

Orisale Md

12 MAIDEN NAME OF MOTHER

Lottie Wilson

13 BIRTHPLACE OF MOTHER

(State or country)

Orisale Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. White

(Address)

Champer Md.

15

Filed

6/20

1914

J. Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 20

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 24 1914, to *June 19* 1914that I last saw her alive on *June 19* 1914and that death occurred on the date stated above, at *12:30 a.m.*

The CAUSE OF DEATH* was as follows:

*Due to accidental abrasion of fingers
on tin can
Septicemia*

(Duration)

yrs.

mos.

26 ds.Contributory
Secondary*Syncope*

(Duration)

yrs.

mos.

ds.

(Signed)

Julius F. Ruby

M. D.

June 20 1914

(Address)

Orisale Md

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Orisale**6/21*

1914

20 UNDERTAKER

ADDRESS

*James F. Wilson**Orisale Md*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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